	-	ID HUMAN SERVICES MEDICAID SERVICES				M APPROVED 0. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DAT	E SURVEY PLETED
		146047	B. WING		12	2/04/2014
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	VILLAGE			1200 EAST GRANT STREET MACOMB, IL 61455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F OC	00		
	Annual Licensure an	d Certification				
F 221 SS=D	An Extended Survey 483.13(a) RIGHT TO PHYSICAL RESTRA	BE FREE FROM	F 22	21		
	physical restraints im	right to be free from any posed for purposes of ence, and not required to edical symptoms.				
	by: Based on interview, review, the facility fail consent for the use o use of a restraint with and document a med use of a restraint for o	is not met as evidenced observation and record ed to obtain informed f a restraint, care plan the a reduction plan in place, ical symptom justifying the one of three residents s in the sample of fifteen.				
	Findings include:					
	On 12/01/14 at 1:00 p Administrator, stated residents using restra	the facility currently has no				
	an enclosed walker n facility's rehabilitation Assistant, asked R1 t and R1 was unable to	o.m., R1 was ambulating in ear the television area of the wing. E7, Certified Nursing o open the enclosed walker, o follow this command. E7 (R1) cannot always open it				
	R1's current medical	record does not contain an				
BORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER WESLEY VILLAGE 146047 B. WING 12/04/2014 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/05/2014 APPROVED). 0938-0391
MARE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE WESLEY VILLAGE 1200 EAST GRANT STREET (pd.)D PRETK TO EXAMMARY STATEMENT OF DEPENDENCE EXAMPLE OF INCOMESTIC ADDRESS DE PTULL REQUILITION OF LSCIENTIFYING INFORMATION) D PRETK PROVIDERS AND CODERCTION DEPONDERS TANGE CODERCTION INCOMESTIC ADDRESS, CITY, STATE, ZP CODE CODE 1200 EAST GRANT STREET MACOMB, L 14465 (pd.)D PRETK TO EXAMPLE OF INFORMATION D PRETK RCD ADDRESS ADDRESS DE PTULL INCOMESTIC ADDRESS, CITY, STATE, ZP CODE CODE 1200 EAST GRANT STREET MACOMB, L 14465 F 221 Continued From page 1 assessment with alternatives attempted or documentation of Informed consent obtained prior to initiation of the use of R1's enclosed walker. F 221 R1's care plan dated 9/2/14 did not document R1's enclosed walker as an identified problem with goals and interventions for a reduction plan in place. F 221 The facility's Restrictive Devices policy dated 1/20/11 states, "All restrictive devices must have the consent of the resident or if incompatent the responsible party(E18, Restorative Nurse) will complete assessment form and together with the interdisciplinary team they will assess the need for the deviceThe use of any restrictive devices will be assessed for reduction and elimination by the care plan team." On 12/02/14 at 12:00 p.m., E8, Minimum Data Set/Care Plan Coordinator, stated. "(R1's enclosed walker) when asked." E8 then stated no assessment with alternatives attempted or informed consent was obtained prior to initiation of R1's enclosed walker. Te8 has ostated that R1 currently does not have a care plan in place	AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	, í			. ,	
120 EAST GRANT STREET MACOME, IL 61455 PRETX TAG SUMMARY STATEMENT OF DEPRIENCIES (BACH DEPRIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEPRIENCY DPERX TAG PREEX (PROVER'S FLAN OF CORRECTION (EACH OORGENT ACTION OF CORRECTION) (EACH OORGENT ACTION OF CORRECTION) DEFICIENCY OCCOMPTING (CONTROL (C			146047	B. WING	 		12/	04/2014
WESLEY VILLAGE MACOMB, IL 61455 [PAU]D PREFIX TAC ISUMMARY STATEMENT OF DEFICIENCIES RECOLUTION OF CORRECTION RECOLUTION OR USCIDENTIFYING INFORMATION ID DEFICIENCY MOST SERVICES DE YPULL RECOLUTION OR USCIDENTIFYING INFORMATION ID DEFICIENCY OF USCIDENTIFYING INFORMATION OCO DEFICIENCY OF USCIDENTIFYING INFORMATION OCO DEFICIENCY OF USCIDENTIFYING INFORMATION OCO DEFICIENCY Continued From page 1 assessment with alternatives attempted or documentation of informed consent obtained prior to initiation of the use of R1's enclosed walker. F 221 R1's care plan dated 9/2/14 did not document R1's enclosed walker as an identified problem with goals and interventions for a reduction plan in place. F 21 R1's current electronic physician order for the use of R1's enclosed walker or any parameters for its use. F 11 The facility's Restrictive Devices policy dated 1/20/11 states, "All restrictive devices must have the consent of the resident or fit incompetent the responsible party(E18, Restorative Nurse) will complete assessment form and together with the interdisciplinary team they will assess the need for the device The use of any restrictive devices will be assessed for reduction and elimination by the care plan team." On 12/02/14 at 12:00 p.m., E8, Minimum Data Set/Care Plan Coordinator, stated, "(R1's enclosed walker) didn't fit what I consider a restraint Decause II doesn't limit access to (R1's) own body. (R1) cannot open or leases II (enclosed walker) was obtained prior to initiation of R1's enclosed walker. E8 also stated that R1 (currently does not have a care plan in place	NAME OF PF	ROVIDER OR SUPPLIER				ODE		
Preprint TXG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG CROMERTING ARCONCETIVE ACTION SHOULD BE CROSS-REFERENCES OF THE APPROPRIATE COMPLETE DEFICIENCY F 221 Continued From page 1 assessment with alternatives attempted or documentation of informed consent obtained prior to initiation of the use of R1's enclosed walker. F 221 R1's care plan dated 9/2/14 did not document R1's enclosed walker as an identified problem with goals and interventions for a reduction plan in place. F 1's enclosed walker does not document a medical symptom justifying the use of R1's enclosed walker or any parameters for its use. F 1's enclosed walker or any parameters for its use. The facility's Restrictive Devices policy dated 1/20/11 states, "All restrictive devices must have the consent of the resident or in incompleten the responsible party(E18, Restorative Nurse) will complete assessment form and legither with the interdisciplinary team they will assess the need for the deviceThe use of any restrictive device must be reflected in the resident care planthe continued use of restrictive devices to (R1's) enclosed walker) didn't fit what I consider a restraint because it doesn't limit access to (R1's) own body(R1) cannot open or release it (enclosed walker) what askent/" E8 then stated no assessment with alternative E8 also stated that R1 currently does not have a care plan in place	WESLEY V	/ILLAGE						
assessment with alternatives attempted or documentation of informed consent obtained prior to initiation of the use of R1's enclosed walker. R1's care plan dated 9/2/14 did not document R1's enclosed walker as an identified problem with goals and interventions for a reduction plan in place. R1's current electronic physician order for the use of R1's enclosed walker does not document a medical symptom justifying the use of R1's enclosed walker or any parameters for its use. The facility's Restrictive Devices policy dated 1/20/11 states, "All restrictive devices must have the consent of the resident or if incompetent the responsible party[E18, Restorative Nurse) will complete assessment form and together with the interdisciplinary team they will assess the need for the deviceThe use of any restrictive device must be reflected in the resident care planthe continued use of restrictive devices will be assessed for reduction and elimination by the care plan team." On 12/02/14 at 12:00 p.m., E8, Minimum Data SetCare Plan Coordinator, stated, "(R1's enclosed walker) didn't fit what I consider a restriant because it doesn't limit access to (R1's) own body. (R1) cannot open or release it (enclosed walker) when asked." E8 then stated no assessment with alternatives attempted or informed consent was obtained prior to initiation of R1's enclosed walker. E8 also stated that R1 currently does not have a care plan in place	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD B HE APPROPRIA		COMPLETION
F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) F 225		assessment with alter documentation of info to initiation of the use R1's care plan dated R1's enclosed walker with goals and interver in place. R1's current electronii of R1's enclosed wal medical symptom just enclosed walker or ar The facility's Restriction 1/20/11 states, "All re- the consent of the rest responsible party(E complete assessment interdisciplinary team for the deviceThe us must be reflected in th continued use of restr assessed for reduction care plan team." On 12/02/14 at 12:00 Set/Care Plan Coordi enclosed walker) didr restraint because it do own body. (R1) cann (enclosed walker) why no assessment with a informed consent was of R1's enclosed walker) why no assessment with a informed consent was	rnatives attempted or rmed consent obtained prior of R1's enclosed walker. 9/2/14 did not document as an identified problem entions for a reduction plan c physician order for the use ker does not document a tifying the use of R1's ny parameters for its use. we Devices policy dated strictive devices must have sident or if incompetent the 18, Restorative Nurse) will t form and together with the they will assess the need se of any restrictive device he resident care planthe rictive devices will be n and elimination by the p.m., E8, Minimum Data nator, stated, "(R1's n't fit what I consider a pesn't limit access to (R1's) ot open or release it en asked." E8 then stated alternatives attempted or s obtained prior to initiation ter. E8 also stated that R1 ve a care plan in place f R1's enclosed walker.					

Facility ID: IL6009864

	-	D HUMAN SERVICES				FORM): 12/05/2014 APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE	
		146047	B. WING		_	12/	04/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WESLEY	VILLAGE			1200 EAST GRANT STREE MACOMB, IL 61455	ET		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 225	Continued From page	. 0					
F 225 SS=F	Continued From page INVESTIGATE/REPC		F 22	5			
00-1	ALLEGATIONS/INDI						
	The facility must not e	employ individuals who have					
	been found guilty of a	busing, neglecting, or					
		by a court of law; or have into the State nurse aide					
		buse, neglect, mistreatment					
	of residents or misapp	propriation of their property;					
		edge it has of actions by a n employee, which would					
		service as a nurse aide or					
	-	e State nurse aide registry					
	or licensing authoritie	S.					
	The facility must ensu	ire that all alleged violations					
	involving mistreatmer						
	including injuries of un misappropriation of re	sident property are reported					
		ministrator of the facility and					
		cordance with State law					
	State survey and cert	rocedures (including to the ification agency).					
	_						
	-	e evidence that all alleged					
	prevent further potent	hly investigated, and must ial abuse while the					
	investigation is in prog						
	The results of all inve	stigations must be reported					
	to the administrator of						
	-	other officials in accordance					
		ing to the State survey and vithin 5 working days of the					
		eged violation is verified					
	appropriate corrective	action must be taken.					

Facility ID: IL6009864

If continuation sheet Page 3 of 18

	-	D HUMAN SERVICES MEDICAID SERVICES				PRINTED: 1 FORM AF OMB NO. 0	PPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SUF COMPLET	RVEY
		146047	B. WING		_	12/04/	2014
NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WESLEY	/ILLAGE			1200 EAST GRANT STREE MACOMB, IL 61455	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)	-	(X5) OMPLETION DATE
F 225	Continued From page	3	F 225	5			
	by:	is not met as evidenced ce resulted in two deficient					
	facility failed to identifi ensure that actual phy immediately to the Ad prevent further potent State agency for four R11) reviewed for abu	eview and interview, the y potential physical abuse, ysical abuse was reported ministrator, investigate to ial abuse and report to the of 15 residents (R1, R2, R9, use, in a sample of 15. This al to affect all 70 residents.					
	The Facility's Abuse a Policy, dated 10/18/13 Administrator is the all same policy document involving mistreatment including injuries of un reported immediately other officials in accor to the state survey an facility "will investigate incidents shall be initii (state agency) as soo to exceed 24 hours at incident." The same p "Resident as Perpetra staff member or indivious or neglect perpetrated immediately report the coordinator."	buse coordinator." The tts: "All alleged violations it, neglect or abuse hknown sourceare to be to the administratorand to rdance to state law including d certification agency." The e all allegations of abuseall ally reported in writing to n as possible, but ought not fter discovery of the policy documents under ator of Abuse Protocol: a dual who observes abuse d by another resident shall e matter to the abuse					
		atant Administrator stated gations of abuse for the					

Facility ID: IL6009864

If continuation sheet Page 4 of 18

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/05/2014 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE	
		146047	B. WING			12/	04/2014
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	VILLAGE				I200 EAST GRANT STREET MACOMB, IL 61455		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page year.	e 4	F	225			
	documents R2 "extrements aff and other resident (Nursing Assistant) in tried to bite (E4). Hit at Nursing Assistant). Mustaff. Pushed at and the (R2's) teeth at (R1)." Under the section title no notifications found under the section title (Director of Nursing) where the section title agency was informed by the section title (Director of Nursing) where the section title agency was informed by the section title agency was informed by the section title agency was informed by the section title agency was set when R9 came out. For and shoved R2, R2 the section titled agency with no documents the same formed by the section title agency is a set with no documentation (Administrator). This is document the state agency way, R2 stump balance and fell on the the section title agencies/people notification agencies/people notification agencies/people notification to the section title agency is a set of the section title agency is a set of the section the state agency is a set of the section the section the state agency is a set of the section the se	ated 6/18/14 at 11:55 p.m. anding outside R9's room, R9 grabbed R2 by the arm ben punched R9 in the left orm documents under the beople notified; family/(POA) be same form documents (DON) notified on 6/20/14 n of notification to E1 ncident form did not gency was informed. dated 11/16/14 at 10:19 p.m. rying to get R2 away from s shirt sleeve. R2 began bead, R11 pushed R2's bled backwards, lost e floor, landing on R2's hip.					

Facility ID: IL6009864

If continuation sheet Page 5 of 18

	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM): 12/05/2014 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED	
		146047	B. WING			12/	04/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WESLEY	VILLAGE			1200 EAST GRANT STREI MACOMB, IL 61455	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	 and E2 (DON) notified computerized inciden incident with R11 date written notation docur notified on 11/16/14. On 12/2/14 at 1:30 p. verified E1 did not inv 6/7/14, 6/18/14 and 1 verified the signature "could be the first time reviewed." 2. Based on interview facility failed to do a fi check for two direct c Certified Nursing Assi Practical Nurse/LPN). potential to affect all 7 Findings include: Facility's Health Care Policy, dated 11/10/13 policy that all employe check completedTh livescan vendor and the collected electronical Department of State F days after signing the disclosure form." 1. Facility's Employee 	d 11/17/14. R2's t report for the same ed 11/16/14 contains a hand menting E2 (DON) was m. E1 (Administrator) estigate the incidents on 1/16/14 as abuse. E1 also page on the incident forms e the incident was and record review the ingerprint based background are staff members (E3 istant), E4 (Licensed . This failure has the 70 residents. Worker Background Check 3, states, "It is the facility's ees have a criminal history e employee shall go to the nave his or her fingerprints y and transmitted to the Police within 10 working	F 225				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		146047	B. WING			12/	04/2014
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WESLEY	VILLAGE				200 EAST GRANT STREET //ACOMB, IL 61455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 225	Authorization docume disclosure on 8/8/14. E3's Employee file ha the date E3's fingerpr 2. Facility's New Emp 8/1-12/1/14, documer on 11/18/14. E4's Health Care Wor Authorization docume disclosure on 11/18/1 E4's Agency fingerpri that E4 has an appoin fingerprinting to be do On 12/2/14 at 11:20 a stated, "We attempt to within 30 days. E3 wa there is no confirmation the same day as E3's was 11/18/14 and E4' 12/4/14. E4 has been E4 was hired. " E1 (A and confirmed this inf The Resident Census dated 12/1/14 and sig (Minimum Data Set C residents reside in the	rker Background Check ents that E3 signed this as no documentation stating inting was done. Noyee document, dated nts that E4 (LPN) was hired rker Background Check ents that E4 signed this 4. nting submission form states intment on 12/4/14 for E4's one. a.m., E5 (Payroll Manager) o fingerprint new employees as fingerprinted on 9/17/14 on slip but it was done on a drug testingE4's hire date 's fingerprint appointment is working on the floor since dministrator) was present formation. a and Condition Report, gned by E8 MDS Coordinator coordinator), documents 70 e facility.		225			
F 226 SS=F	483.13(c) DEVELOP/ ABUSE/NEGLECT, E	IMPLMENT TC POLICIES slop and implement written	F	226			

Facility ID: IL6009864

If continuation sheet Page 7 of 18

	-					FORM	: 12/05/2014 APPROVED
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE S COMPL	
		146047	B. WING		_	12/0	04/2014
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WESLEY	/ILLAGE			1200 EAST GRANT STREI MACOMB, IL 61455	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page mistreatment, neglect and misappropriation	t, and abuse of residents	F 226				
	by: Based on record revi failed to follow operat procedures regarding investigation and prev four of 17 residents (F for abuse, in a sample potential to affect all 7 Findings include: The Facility's Abuse a Policy dated 10/18/13 Administrator is the al same policy document involving mistreatment including injuries of un reported immediately other officials in accor to the state survey an facility "will investigate incidents shall be initii (state agency) as soo to exceed 24 hours af incident." The same p	the identification, reporting, vention of physical abuse for R1,R2, R9, R11) reviewed e of 17. This failure has the 70 residents. and Neglect Prevention b documents "the buse coordinator." The hts: " all alleged violations at, neglect or abuse nknown sourceare to be to the administratorand to rdance to state law including id certification agency." The e all allegations of abuseall ally reported in writing to on as possible, but ought not					
	or neglect perpetrated immediately report the coordinator." On 12/1/14 E17 (Assi	idual who observes abuse d by another resident shall e matter to the abuse istant Administrator/AA) no allegations of abuse for					

Facility ID: IL6009864

If continuation sheet Page 8 of 18

		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 12/05/2014 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		146047	B. WING		1	2/04/2014
NAME OF PI	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP	CODE	
WESLEY	VILLAGE			200 EAST GRANT STREET MACOMB, IL 61455		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 226	Continued From page the year.	8	F 226			
	documents R2 "extrements aff and other resider (Nursing Assistant) in tried to bite (E4). Hit at Nursing Assistant. mass staff. Pushed at and t (R1's) teeth at (R1)." under the section title no notifications found under the section title (DON/Director of Nurse incident on 6/11/14. This document the state age R2's incident report d documents R2 was ste when R9 came out R2 and shoved R2. R2 th jaw area. The same for section titled agency/(POA/Power of Attorn documents under sign on 6/20/14 with no do to E1 Administrator. T document the state age R11's incident report of documents R11 was the R13 by pulling on R2' punching R11 in the rhands away. R2 stumbalance and fell on the This computerized for agencies/people notif	the nose with (R1) fist. Also at (R15) CNA (Certified ade attempts to bite other ried to bite (R1). Bared The same form documents d agencies/people notified: . The same form documents d signatures, E2 sing) was notified of the nd E1(Administrator) was incident form did not gency was informed. ated 6/18/14 at 11:55 p.m. tanding outside R9's room, 9 grabbed R2 by the arm hen punched R9 in the left prom documents under the people notified; family ey. The same form natures: E2 (DON) notified cumentation of notification This incident form did not gency was informed. dated 11/16/14 at 10:19 p.m. trying to get R2 away from s shirt sleeve. R2 began head, R11 pushed R2's ibled backwards, lost e floor, landing on R2's hip.				

Facility ID: IL6009864

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,		CONSTRUCTION	(X3) DATE		
		146047	B. WING			12/	04/2014
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	•	
WESLEY	/ILLAGE				200 EAST GRANT STREET IACOMB, IL 61455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 226	On 12/2/14 at 1:30 p. verified E1 did not inv 6/7/14, 6/18/14 and 1 verified the signature "could be the first time reviewed." On 12/2/14 at 1:10 p. Nursing) stated after altercation the nurse would decide if E1 (A notified." E2 stated re altercations become a than one target but E final decision." On 12/2/14 at 1:20 p. Nursing Assistant) sta E9 (Social Service Di resident hit another re to resident abusere would report to E2 DO Nursing)then E9. On 12/2/14 at 1:15 p. Nursing Assistant) sta altercations are a "be back here." The Resident Census dated 12/1/14 and sig	E2 (DON) notified 11/17/14. m. E1 (Administrator) restigate the incidents on 1/16/14 as abuse. E1 also page on the incident forms e the incident was m. E2 DON (Director of a resident to resident would notify E2 and E2 dministrator) "needed to be resident to resident abuse when there is "more 1 Administrator "makes the m. E6 CNA (Certified ated the abuse coordinator is rector). E6 stated if a esident it would be resident port to nursethe nurse DN (Director of m. E7 CNA (Certified ated resident to resident haviorhappens all the time s and Condition Report, gned by E8 MDS Coordinator coordinator), documents 70 e facility. ACCIDENT		323			
33-6							

Facility ID: IL6009864

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	-	D HUMAN SERVICES					FORM): 12/05/2014 APPROVED
STATEMENT O	CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		• •		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		146047	B. WING			_	12/	04/2014
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
WESLEY	/ILLAGE				I200 EAST GRANT STREE MACOMB, IL 61455	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323	as is possible; and ea	ire that the resident as free of accident hazards	F	323				
	by: Facility noncompliant practices. 1. Based on interview review the facility faile interventions after east fall prevention care pl residents (R1) review fifteen. This failure re sustaining a hairline fir requiring sutures to R Findings include: R1's Incident Report of R1 fell at the facility w walker on 1/17/14. Th no new intervention w instructed facility staff R1's Incident Report of R1 fell at the facility w walker on 1/26/14. Th the intervention, "Staff direct supervision at a R1's Incident Report of	ed for falls in the sample of sulted in R1 falling and racture of R1's nose, and 1's forehead. dated 1/17/14 documents thile using an enclosed his same report documents ras implemented and t, "Continue to monitor." dated 1/26/14 documents thile using an enclosed his same report documents f reminded to keep (R1) in all times," was implemented. dated 3/13/14 documents						
		enclosed walker at the						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/05/2014 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE	
		146047	B. WING				12/	04/2014
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZI	P CODE		
WESLEY	VILLAGE				1200 EAST GRANT STREET MACOMB, IL 61455			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
F 323	facility on 3/13/14. The no new intervention wintervention, "Remind supervision while in (a continued. R1's Care Plan dated following interventions monitorremind staff at all times while in the staff to keep (R1) in d when (R1) is in (enclosed) R1's Incident Report of fell at the facility on 52 documents, "Heard of hallway. (R1) had tip Lying on side. Has a side of forehead. Has shaped gash on nose bleedingtook reside department) to be eva R1's Emergency Roo documents R1 had a to R1's forehead, and repair the laceration. documents R1 receive Tomography scan of t bilateral nasal fracture On 12/04/14 at 10:05 Nursing, verified that 5/6/14 was unwitness On 12/4/14 at 11:00 a stated that E1 expects implemented after a r	his same report documents vas implemented and the staff (R1) needs constant enclosed walker)," was 4/14/14 documents the s: "Continue to that (R1) needs supervision e (enclosed walker)remind lirect supervision at all times osed walker). dated 5/6/14 documents R1 '6/14. This same report uttering sound down ped over (enclosed walker). half inch size gash on right a quarter inch horseshoe . Forehead and nose both nt to (local emergency aluated." m record dated 5/6/14 three centimeter laceration R1 received four sutures to This same record ed a Computerized the head, diagnosing a e. a.m., E2, Director of R1's fall with injury on	F	323				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED		
		146047	B. WING			12/	04/2014		
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE				
WESLEY VILLAGE					1200 EAST GRANT STREET MACOMB, IL 61455				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES I (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE REGULATORY OR LSC IDENTIFYING INFORMATION) T/				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 323	were implemented aff 3/13/14. E1 then stat staff to follow R1's ca interventions on R1's dated 4/14/14 were n 2. Based on interview facility failed to invest staff for two incidents R18 and R19 in the s Findings include: R19's incident report unidentified CNA (Ce asked "the nurse to c another CNA, E12 "ju while being positioner nurse went to check F hit R19's head with R was performing morn documents under sec action taken: "checl right forehead is red a observed facial grima assessment." The sat signatures: E1 Admin E2 DON (Director of I E12's CNA personnel contain education foll 12/15/13. R18's incident form d R18 complained of di R18's face "is hit by ti whilehelped R18 tra the recliner." The san	ter R1's falls on 1/17/14 and ted that E1 expects facility re plan, and verified the fall prevention care plan ot followed on 5/06/14. and record review the igate, analyze and educate involving resident injury for upplemental sample. dated 12/15/13 documents rtified Nursing Assistant) heck (R19) because ist made incident to (R19) d." When the unidentified R19, E12 explained that R19 19's right siderail when E12 ing cares." The same form tion titled Description of ked the head area. noted and hematoma, also ces of pain while doing me form documents under istrator notified 3/17/14 and Nursing) notified 12/17/13. file reviewed and did not owing the incident on ated 1/22/14 documents scomfort and tells nurse	F	323					

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DEPARTMENT OF HEALTH AND F CENTERS FOR MEDICARE & ME					FORM	: 12/05/2014 APPROVED . 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	146047	B. WING			12/0	04/2014
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
WESLEY VILLAGE		200 EAST GRANT STREI IACOMB, IL 61455	ET			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 F 323 Continued From page 13 R18's left face. Applied ic face." The same form do was witnessed by E9 (SS Director). On 12/3/14 at 2:15 p.m. I the incident on 1/22/14 tf hit R18. E9 verified E9 di statement. On 12/3/14 E1 Administr (Certified Nursing Assista did not contain education 1/22/14. E1 identified E1 the incident dated 1/22/1 On 12/3/14 at 2:15 p.m. I concern for the incidents 1/22/14. E1 stated "I knot things happen." E1 verifie were not held after the in 1/22/14. Based on interview an facility failed to ensure th (R4) reviewed for oxyger sample of fifteen was kep in use. Findings include: On 12/02/14 at 10:35 a.m an electric hair dryer in tf R4 was wearing a nasal receiving oxygen from a attached to the back of R 	ce pack on R18's left cuments the incident SD/Social Service E9 (SSD) stated during he lifting machine did not id not fill out a witness ator provided E11's CNA ant) personnel file which h following the incident on 1 as the CNA involved in 4. E1 stated "I did not see on 12/15/13 and bw the staff and in life, ed additional inservices incidents on 12/15/13 and d record review, the hat one of three residents in administration in the pt safe while oxygen was m., R4 was sitting under he facility's beauty shop. cannula and was portable oxygen tank	F 323				

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					FORM	: 12/05/2014 APPROVED
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
	146047	B. WING		_	12/0	04/2014
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
WESLEY VILLAGE		200 EAST GRANT STREI IACOMB, IL 61455	ET			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
under a hot electric hair On 12/02/14 at 10:46 a.r confirmed the presence in the beauty shop durin and stated, "It (oxygen u (E13) didn't know that it On 12/04/14 at 8:30 a.m stated the facility does n for staff guidance specifi beauty shop. F 329 483.25(I) DRUG REGIM SS=D UNNECESSARY DRUG Each resident's drug reg unnecessary drugs. An drug when used in exces duplicate therapy); or for	m., E13, Hairdresser n was in use while R4 sat dryer. m., E1, Administrator, of oxygen administration ig use of an electric dryer use) shouldn't be in there. shouldn't be." n., E1, Administrator not have a policy in place ic to oxygen use in the IEN IS FREE FROM SS gimen must be free from unnecessary drug is any ssive dose (including r excessive duration; or oring; or without adequate r in the presence of which indicate the dose scontinued; or any sons above. sive assessment of a st ensure that residents bsychotic drugs are not s antipsychotic drug treat a specific condition mented in the clinical ho use antipsychotic ose reductions, and , unless clinically	F 323				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	RM APPROVED	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED	
		146047	B. WING		1	2/04/2014	
NAME OF P	ROVIDER OR SUPPLIER		- 1 T	STREET ADDRESS, CITY, STATE, ZIP CODE			
WESLEY VILLAGE				1200 EAST GRANT STREET MACOMB, IL 61455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 329	Continued From page	e 15	F 3	29			
	by: Based on observatio review the facility faile warrant the use of an residents (R1, R2) an justification to warran antipsychotics for one reviewed for antipsyc Findings include: 1. R1's current electro document the order for medication, "Olanzap bedtime." On 12/2/14 at 10:03 a reclining chair in the t facility's Rehabilitation On 12/1/14 at 9:20 a. p.m., R1 was ambula the facility's Rehabilit cooperative and no p noted during these tin On 12/02/14 at 1:40 p Set/Care Plan Coordi being monitored for tt Physical Aggression f food, and exit seeking physically aggressive	e of four residents (R9) hotics in a sample of 15. onic physician orders or the antipsychotic ine 7.5 milligrams at a.m., R1 was asleep in a relevision lounge of the n Wing. m. and 12/02/14 at 3:15 ting in an enclosed walker in ation Wing. R1 was sychiatric behaviors were					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/05/2014 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		146047	B. WING				12/	04/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STAT	E, ZIP CODE		
WESLEY VILLAGE				00 EAST GRANT STREET ACOMB, IL 61455				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page aggression towards o 2. R2's current electr document the order for medication, "Olanzap bedtime." On 12/1/14 at 1:30 p. a.m. and 3:15 p.m., R couch near the televis Rehabilitation Wing. On 12/02/14 at 1:40 p Set/Care Plan Coordi being monitored for th increased anxiety, res symptoms of depress behaviors do not warr antipsychotic medicat Lexi-Comps Drug Info Nursing (8th Edition d "Antipsychotic Medica must be persistent." On 12/2/14 at 8:30 a. Set/Care Plan Coordi able to track the occu last 30 days and it on occurrences per shift. could not provide doc behaviors exhibited b 3. R9's current medic	e 16 ther residents. onic physician orders or the antipsychotic ine 7.5 milligrams at m., and 12/2/14 at 10:03 2 was sleeping on the sion lounge of the facility's o.m., E8, Minimum Data nator, confirmed that R2 is he following behaviors: sisting cares, and signs and ion. E8 then verified these rant the use of an ion. ormation Handbook for lated 2007) documents, ation Guidelinesbehaviors m., E8, Minimum Data nator, stated, "We are only rrence of behaviors for the ly tracks the number of " E8 verified the facility umentation of consistent y R1 and R2. al record documents R9 is	F 32	29				
	and was ordered 11/2 bedtime, last increase documents R19's diag	mg (milligram) at bedtime 6/13, and Haldol 2 mg at ed 8/26/14. The same record gnosis include Dementia bances, psychosis and						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/05/2014 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		146047	B. WING			_	12/	04/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WESLEY VILLAGE					200 EAST GRANT STREE IACOMB, IL 61455	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page anxiety.	17	F	329				
	documents "R9 is cur 1 mg at bedtime and Black Box Warning: Ir patients with dementia patients with dementia with atypical antipsycl increased risk of deat conventional antipsyc mortality.	g Physician dated 6/24/14 rently receiving Risperidone Haldol 0.5 mg at bedtime. hcrease mortality in elderly a-related psychosis: Elderly a-related psychosis treated hotic medications are at htreatments with hotic drugs may increase						
		were reviewed and do not						
	R9's summary of phy 11/26/13-10/28/14 we contain justification fo antipsychotics.	re reviewed and did not						
	Set Coordinator state	use that is what the doctor						
	Nursing, 8th Edition d Coadministration of tv does not have any ph	prmation Handbook for lated 2007 documents vo or more antipsychotics armacological basis or d increases the potential for						

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